Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

ALLIED MEDICAL CENTERS
PO BOX 24809
HOUSTON TX 77029

Respondent Name
INDEMNITY INSURANCE CO OF NORTH

Carrier's Austin Representative
Box Number 15

MFDR Tracking Number
M4-11-1864-01

MFDR Date Received
February 7, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "TDI rules states that it is not enough for a carrier for file a TWCC Denial code and that the carrier is required to submit claim specific language. The denial code and their description are too vague for our facility to determine the basis for the denial. While the denial itself is understandable, it does not apply in this case. This denial is not in compliance with Rule §133.3."

Amount in Dispute: $106.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Carrier stands on previously reviewed and audited bill. The Provider is improperly billing 99213 with 99455."

Response Submitted by: Indemnity Insurance Company of North America

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 13, 2010	99213	$106.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the fee guideline for professional medical services.
3. 28 Texas Administrative Code §134.204 sets out the Medical Fee Guideline for Workers' Compensation Specific Services.

4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - 2 – Any reduction is in accordance with the FOCUS-Aetna Workers Comp Access LLC contract
   - 4 –The charge for this report exceeds usual and customary charges by other providers for similar reports
   - 5 –This procedure is mutually exclusive to another on this date of service. By clinical practice standards, this procedure should not or cannot be performed in the same treatment period.
   - 6 – Significant, separately identifiable evaluation and management service by the same Physician on the day of a procedure.

Issues

1. Was the workers' compensation insurance carrier entitled to pay the health care provider at a contracted rate?
2. Did the requestor submit the bill pursuant to 28 Texas Administrative Code §134.204 (C)?
3. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier reduced disputed services with reason code "2 – Any reduction is in accordance with the FOCUS-Aetna Workers Comp Access LLC contract*."* Review of the submitted information found insufficient documentation to support that the disputed services were subject to a contractual fee arrangement between the parties to this dispute. Nevertheless, on March 15, 2011, the Division requested the respondent to provide a copy of the referenced contract as well as documentation to support notification to the healthcare provider, as required by 28 Texas Administrative Code §133.4, that the insurance carrier had been given access to the contracted fee arrangement. Review of the submitted information finds that the documentation does not support notification to the healthcare provider in the time and manner required. The Division concludes that pursuant to §133.4(g), the insurance carrier is not entitled to pay the health care provider at a contracted fee. Consequently, per §133.4(h), the disputed services will be reviewed for payment in accordance with applicable Division rules and fee guidelines.
2. Per 28 Texas Administrative Code §134.204 (j)(2)(C) "If the examining doctor determines MMI has been reached and an IR evaluation is performed, both the MMI evaluation and the IR evaluation portions of the examination shall be billed and reimbursed in accordance with paragraphs (3) and (4) of this subsection. (3) The following applies for billing and reimbursement of an MMI evaluation. (A) An examining doctor who is the treating doctor shall bill using CPT Code 99455 with the appropriate modifier. (i) Reimbursement shall be the applicable established patient office visit level associated with the examination. (ii) Modifiers "V1", "V2", "V3", "V4", or "V5" shall be added to the CPT code to correspond with the last digit of the applicable office visit."

   The requestor seeks reimbursement for CPT code 99213-25. Denied by the insurance carrier with denial reason codes "5 –This procedure is mutually exclusive to another on this date of service. By clinical practice standards, this procedure should not or cannot be performed in the same treatment period" and "6 – Significant, separately identifiable evaluation and management service by the same Physician on the day of a procedure." The requestor appended modifier -25 defined by the AMA CPT Code book as "Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service."
3. The requester submitted a bill for CPT codes 99080-73, 99213-25 and 99455-VR. The requestor disputes non-payment of CPT code 99213-25. Review of the submitted documentation does not support the billing of CPT code 99213-25; as a result, the requestor is not entitled to reimbursement for CPT code 99213-25.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		November 14, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.